DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

MAR 3 1 2014

PRINTED: 03/13/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		LOCATICICATION AS IMPED.		IG	COMPLETED	
		44 <u>A</u> 114	B. WING _		03/12/201	4
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	
SS≃F ABORĄTQRY	The facility must - (1) Procure food fro considered satisfact authorities; and (2) Store, prepare, under sanitary cond This REQUIREMENT by: Based on observate manufacturer's san staff interview, the failed to maintain a equipment and faile manufacturer's reconsolution in the three The findings include Observation on Mar the dietary department on the rungs. Further build-up of ice on the walk-in freezer door revealed the three conserved inverted par revealed the dietary compartment sink of Further observation DIRECTOR'S OR PROVIDE	om sources approved or story by Federal, State or local distribute and serve food ditions NT is not met as evidenced ion, review of the litizer recommendations, and facility dietary department sanitary dietary department, and to maintain the example of sanitizer ecompartment sink.	F 37	refrigerator were cleaned by staff on 3/11/14. 2. All kitchen equipment will be clean and will be placed on a cleaning schedule. 3. Dietary staff will be in-service quarterly by the RD and/or C regarding infection control are cleaning of kitchen equipment. 4. This corrective action will be by the CDM for 30 days. The conduct an audit monthly unter are identified for 3 consecutive. The Infection Control Nurse conduct random spot checks to ensure proper procedures a followed. #2 1. The ice build-up on the floor side of the walk-in freezer do removed on 03/11/14. 2. Checking the freezer for ice accumulation will be added to routine cleaning for dietary st. 3. The sweep on the walk-in free replaced by the Environmenta Director on 03/14/14. 4. This corrective action will be by the CDM weekly for 30 day Environmental Services Direct monitor monthly until three comonths of compliance are extractional services are extractive action.	dietary kept routine ed DM deproper at. monitored e RD will il no issues we months. will for 30 days re being 4/18. on either or was the aff. ezer was al Services monitored ays. The ctor will consecutive nibited.	2000 - 20
(\mathred{\pi}	ider Sperich			Administractor	03/27/	/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Burney Same

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		44A114	B. WING		03/12/2014		
NAME OF PROVIDER OR SUPPLIER LAKESHORE HEARTLAND			STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE NASHVILLE, TN 37214				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
F 371	strip did not change sanitizer in the waterevealed there was the sanitizer bottle to Review of the manufor the three compa a Quaternary produmillion. Interview on March the dietary staff mer compartment sink, i confirmed the three test strip did not chatubing from the bottle contained no sanitize. Interview on March the Certified Dietary department, confirmed the floor of the dietary department, with the Confirmed the dietary department, inverted pans stored available for use. Fut the exterior rims had of blackened debris. Interview confirmed the lid of the tilt skilled the range-top spill particles.	color indicating there was nown. Further observation no sanitizer in the tubing from the sanitizer sink faucet. Ifacturer's recommendation rement sink sanitizer level for ct revealed 200-400 parts per 10, 2014, at 6:30 p.m., with more working the three in the dietary department, compartment sink sanitizer inge color and the sanitizer e to the sanitizer sink faucet er. 10, 2014, at 6:45 p.m., with Manager, in the dietary ed the walk-in refrigerator accumulation of rust and oris. Further interview on either side of the walk-in wild-up of ice. Perview on March 11, 2014, at certified Dietary Manager, in the storage rack were rither observation revealed a very heavy accumulation. Further observation and the rear side of the base and at had a greasy build-up, and an had a heavy accumulation.	F 3	cleaned and sanitized by the PM Coon 03/10/14. 2. The dietary staff was in-serviced or protocol usage and checking sanitized level in the 3 compartment sink on 03/11/14. 3. Dietary staff will be in-serviced quarterly by the RD and/or CDM regarding infection control and procleaning of kitchen equipment. 4. This corrective action will be monitive weekly by the CDM for 30 days. Infection Control Nurse will conduct random spot checks for 30 days to ensure proper procedures are being followed until three months of compliance are exhibited.	n the zer per tored The ct 4/18/14 om e ding ent. tored will ssues nths. days		
	interview on March 1	11, 2014, at 11:50 a.m., with			Control of the State of the Sta		

PRINTED: 03/13/2014 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 44A114 B. WING 03/12/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE LAKESHORE HEARTLAND NASHVILLE, TN 37214 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) #5 4/18/14 F 371 Continued From page 1 F 371 1. The tilt skillet was cleaned by dietary strip did not change color indicating there was no staff on 03/11/14. sanitizer in the water. Further observation All kitchen equipment will be kept revealed there was no sanitizer in the tubing from clean and placed on a routine cleaning the sanitizer bottle to the sanitizer sink faucet. schedule. 3. Dietary staff will be in-serviced Review of the manufacturer's recommendation quarterly by the RD and/or CDM for the three compartment sink sanitizer level for regarding infection control and proper a Quaternary product revealed 200-400 parts per cleaning of kitchen equipment. million. This corrective action will be monitored by the CDM for 30 days. The RD will Interview on March 10, 2014, at 6:30 p.m., with conduct an audit monthly until no issues the dietary staff member working the three are identified for 3 consecutive months. compartment sink, in the dietary department, The Infection Control Nurse will confirmed the three compartment sink sanitizer conduct random spot checks for 30 days at test strip did not change color and the sanitizer to ensure proper procedures are being tubing from the bottle to the sanitizer sink faucet followed. contained no sanitizer. #6 4/18/14 The range top spill pan was cleaned by Interview on March 10, 2014, at 6:45 p.m., with 1. the Certified Dietary Manager, in the dietary dietary staff on 03/11/14. department, confirmed the walk-in refrigerator 2. All kitchen equipment will be kept storage units had an accumulation of rust and clean and will be placed on a routine blackened sticky debris. Further interview cleaning schedule. confirmed the floor on either side of the walk-in 3. Dietary staff will be in-serviced freezer door had a build-up of ice. quarterly by RD and/or CDM regarding infection control and proper cleaning of Observation and interview on March 11, 2014, at kitchen equipment. 7:45 a.m., with the Certified Dietary Manager, in This corrective action will be monitored

of blackened debris.

the dietary department, confirmed the numerous

inverted pans stored on the storage rack were

available for use. Further observation revealed

of blackened debris. Further observation and

the exterior rims had a very heavy accumulation

interview confirmed the rear side of the base and

the lid of the tilt skillet had a greasy build-up, and

the range-top spill pan had a heavy accumulation

Interview on March 11, 2014, at 11:50 a.m., with

followed.

by the CDM for 30 days. The RD will

conduct an audit monthly until no issues

are identified for 3 consecutive months.

conduct random spot checks for 30 days

to ensure proper procedures are being

The Infection Control Nurse will

		AND HUMAN SERVICES			·	FORM	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	•			T	<u>. 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
44 <u>A</u> 114		B. WING			03/12/2014		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE HEARTLAND				VILLE, TN 37214		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 SS=E	department by the p confirmed the exter accumulation of bla steel wool would ge 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pro	acility Registered Dietitian, in the dietary intment by the pot and pan storage rack, rmed the exterior rims had a very heavy mulation of blackened debris and "using wool would get it off" 55 INFECTION CONTROL, PREVENT EAD, LINENS facility must establish and maintain an tion Control Program designed to provide a			 On 03/11/14, the ice machine in question was cleaned. On 03/11/14, all ice machines were inspected by the Director of Environmental Services with no problems found. On 03/11/14 		4/18/14 (2. 25 Y/15) k
	safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.			4.	Environmental Services with no problems found. On 03/11/14, housekeeping staff were in-service regarding daily cleaning schedule daily cleaning sign-off sheets. 3. New water and ice chutes were installed on 03/17/14 on the ice machine in question. Ice machine will be inspected weekly by the housekeeping supervisor to ensure compliance.	le and nes ure	

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	M APPROVED O. 0938-0391
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		44A114	B. WING	i		0	3/12/2014
	PROVIDER OR SUPPLIER	·		302	REET ADDRESS, CITY, STATE, ZIP CODE 25 FERNBROOK LANE		<u> </u>
LAILE.				NA	ASHVILLE, TN 37214		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
F 441	(c) Linens Personnel must har	age 3 andle, store, process and as to prevent the spread of	F	441			
	by: Based on observat failed to maintain a	NT is not met as evidenced ation and interview, the facility a clean and sanitary ice/water of for one of two ice/water as observed.					
	The findings include	ed:	İ			•	
	revealed a staff me	ay 11, 2014, at 10:25 a.m., ember entering and exiting the fourth floor with a water	 - 				1 × 2 = 1
	fourth floor pantry ro	ice/water dispenser in the room on March 11, 2014, at ed blackened debris on the tip ser spout.					
	Services on March fourth floor pantry ro blackened debris or	Director of Environmental 11, 2014, at 11:20 a.m., in the com confirmed there was n the water spout of the	i			· .	
	"dirty". Further inter housekeeping staff the machine, there v schedule for the ice.	r and the water spout was riview confirmed the was responsible for cleaning was no routine cleaning e/water dispenser machine, tion of staff cleaning the					
i	1		1			44, 5	